

Wisconsin Department of Health Services

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|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>0018619</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/30/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NEWCASTLE PLACE</b> |                                                                                                                                                                                                         |                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>12600 N PORT WASHINGTON RD</b><br><b>MEQUON, WI 53092</b>                    |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                            | ID<br>PREFIX<br>TAG                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| U 000                                                      | <b>INITIAL COMMENTS</b><br><br>On 07/30/2024, Surveyor conducted a complaint investigation at Newcastle Place. No deficiencies were identified.<br><br>Complaint was unsubstantiated.<br><br>Census: 31 | U 000                                                                       |                                                                                                                          |  |                                                                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE